

# Washington County School District

121 West Tabernacle  
Saint George, Utah 84770  
(p)435-673-3553 Ext: 5138 (f)435-673-3216  
www.washk12.org

## MEDICAL HISTORY FORM

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### CHILD INFORMATION

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Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mother or Legal Guardian: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Work or Cell: (\_\_\_\_) \_\_\_\_\_

Father or Legal Guardian: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Work or Cell: (\_\_\_\_) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Work or Cell: (\_\_\_\_) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Who is completing this Questionnaire?  Mother  Father  Guardian  Caregiver

Other (specify) \_\_\_\_\_

Health Care Professional \_\_\_\_\_ Date \_\_\_\_\_

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### MEDICAL HISTORY

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#### Brief Birth History:

Were there any problems during pregnancy or delivery of student (accidents, illness, infections, etc.)?

Yes  No

➤ If yes, please explain: \_\_\_\_\_

Were there any complications/problems after birth (prematurity, oxygen, hospitalization, etc.)?

Yes  No

➤ If yes, please explain: \_\_\_\_\_

Birth weight: \_\_\_\_\_ Premature? \_\_\_\_\_ If so, how many weeks early? \_\_\_\_\_

**Medical Information:**

Does your child have a medical diagnosis of a chronic health problem (such as diabetes, seizures, cerebral palsy, asthma, down's syndrome, heart, digestive or respiratory disorders, TBI, etc.)?

Yes  No

➤ If yes, please explain: \_\_\_\_\_

Does your child receive medical treatments during or outside the school day (such as oxygen, gastrostomy care, special diet, tracheostomy care, suctioning, injections, etc.)?  Yes  No

➤ If yes, please explain: \_\_\_\_\_

Does your child experience frequent absences and/or hospitalizations due to illness?  Yes  No

➤ If yes, please explain \_\_\_\_\_

Does your child have daily medications?  Yes  No

➤ If yes, please list:

Medications:	What is it for?	How Much?	How often? (Schedule)

Does your child require adjustments to classroom or school facilities (such as temperature control, medication storage, availability of running water, modification for accessibility)?

Yes  No

➤ If yes, please explain: \_\_\_\_\_

Does your child have other special health care needs (such as special precautions in lifting, special transportation, emergency plan, special techniques for feeding and/or positioning)?  Yes  No

➤ If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child have any food, medication, latex, or other allergies?  Yes  No

➤ If yes, please explain:

Food or Substance	Reaction and Treatment

Does your child have any special concerns with their vision and/or hearing?  Yes  No

➤ If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Has your child had any hospitalizations or surgeries?  Yes  No

➤ If yes, please list and include dates: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are there other things you would like to tell us about your child?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_

Person Completing Form: \_\_\_\_\_

Interview:  Yes  No

Position/Title: \_\_\_\_\_

Who Interviewed: \_\_\_\_\_

Signature: \_\_\_\_\_